

BEST PRACTICES FOR INTERDISCIPLINARY COLLABORATION: NURSES  
SUPPORTING THE INTEGRATION OF DOULAS INTO A CARE TEAM

By

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### Abstract

Doulas are becoming more common at hospital births in the United States, and nurses are working alongside doulas to support laboring women more frequently. Using research obtained from a literature review and the personal experience of the author as a doula, this paper aims to create best practice recommendations for nurses to support the integration of doulas into the care team. Findings of this review suggest that many nurses are unfamiliar with the role of the doula and could benefit from education on the doula scope of practice and role on the care team. Research and expert opinion support the creation of hospital-based doula programs to encourage oversight of doulas and collaboration between doulas and nurses.

## CHAPTER I

### Introduction

#### **Statement of Purpose**

This thesis aims to develop best practice recommendations for nurses to work alongside doulas while providing care to laboring women. This paper will examine the most recent research on the role of the doula in a care team and provide recommendations on how to integrate doulas into a care team and overcome possible barriers to collaboration. The existing research on the benefit of continuous labor support and its relevance to the nursing practice will be addressed. Current research, expert opinion, and the statements of professional organizations on the role of the doula and the relationships between doulas, registered nurses, and other members of the care team will be reviewed. Furthermore, the author will integrate her experience receiving DONA International training and working as a doula in hospital births in Tucson, Arizona into the best practice recommendations discussion. From this information, recommendations will be created on educating registered nurses on the role of the doula and fostering collegial relationships between doulas and the rest of the laboring woman's care team.

#### **Background of Issue Importance**

While global maternal mortality (death of a woman while pregnant or within 42 days of termination of pregnancy) has been decreasing in the past decade, it has been increasing in the United States (MacDorman, Declercq, Cabral & Morton, 2016). This reality is particularly troubling for women of color and low-income women, who are more likely to suffer complications related to delivery or other adverse outcomes than their white, well-off counterparts (Kozhimannil et al., 2014). Women who have cesarean births are more likely to suffer complications, disability, or death (WHO, 2018). The cesarean rate was 31.9% in the U.S.

in 2016 (Martin et al., 2018). The WHO estimates that that the ideal cesarean rate is 10-15% (WHO, 2018).

Furthermore, an estimated \$27 billion was spent on maternity and newborn care in the United States in 2009 (Kozhimannil et al., 2014). Cesarean birth is significantly more costly than vaginal birth – in 2009, the average total cost for a cesarean birth and newborn care was about \$27,900 for commercial payers, compared to \$18,300 for vaginal births (Kozhimannil et al., 2014). Four million infants are born in the U.S. annually. There is a significant financial and public health stake into improving childbirth outcomes, and the kind of continuous labor support that doulas provide is one proposed way to improve outcomes.

Doula care has emerged as a possible bridge for some of the gaps in the obstetric care system in the United States. Doulas are most commonly women who have received some level of training or mentorship in the support of women during a labor and birth. There is no training, certification or license required in order to call oneself a doula. Several organizations exist to provide training in birth support, though DONA International is the largest group to do so. In general, doulas use physical techniques (massage, counter pressure, and hip squeezes) and emotional support to support the comfort and pain level of women in labor (DONA International, 2012). There is no defined scope of practice that applies to every doula, though organizations like DONA International hold their certified doulas to a defined scope of practice and code of ethics (Waller-Wise, 2018; DONA International, 2017).

A useful theoretical framework to view the role of the doula is “fostering relational autonomy,” (Meadow, 2014). Doulas clarify the values of the women they work with; they help women discover their values and provide context for decision-making (Meadow, 2014). Doulas help women identify their options. They see themselves as providing information on all available

options, including those not always supported by hospital obstetric practice (Meadow, 2014). In their interactions with hospital staff, doulas model effective communication. They also act as facilitators of communication between hospital staff and the laboring mother (Meadow, 2014). They encourage women to ask questions and ensure that they fully understand whatever education is provided. Doulas help women make choices by introducing methods of deliberation and decision-making (Meadow, 2014). Finally, doulas facilitate reflection on the birth experience in a systematic, goal-oriented way.

A 2017 Cochrane systematic review examined the effect of continuous labor support on women and their babies. The authors examined 26 trials and found that women who gave birth with a doula were more likely to have a spontaneous vaginal delivery, less likely to require intra-partum analgesia, and less likely to report negative feelings of their experience (Bohren, Hofmeyr, Sakala, Fukuzawa & Cuthbert, 2017). Furthermore, a Cochrane review showed that women were 25% less likely to require a C-section, 8% more likely to have a spontaneous vaginal birth, and their babies were 38% less likely to have low five-minute Apgar scores (Bohren et al., 2017).

The positive influence of doulas does not exist only in quantitative outcomes; women whose births are attended by a doula report better satisfaction with their birth experience. One study in Minneapolis, MN found that doulas increase feelings of agency, improve feelings of personal security, promote autonomy, and decrease feelings of social isolation in laboring women (Kozhimannil et al., 2016). Doulas facilitate conversations with care providers, interpret medical jargon, reinforce education and provide culturally relevant education (Meadow, 2018).

While doulas have the potential to improve outcomes for women and infants, only six percent of women received care from a doula in 2013, up from 3% in 2007 (Declercq, Sakala,

Corry, & Applebaum, 2007; Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013). While most women did not have doulas, more than a quarter of those women (27%) expressed interest in receiving doula care (Declercq et al., 2013). Continuous labor support has no known risks to the mother and the infant and is therefore a very promising intervention to improve outcomes for childbearing women and their infants. However, nurses are not necessarily trained in how the doula fits into the care team, or how to provide effective non-pharmacologic support to laboring women (Roth, Henley, Seacrist & Horton, 2016).

The educational background and training of the doula and the nurse are very different, but there is some overlap between roles. Many labor and delivery nurses are not trained to work alongside doulas, and adversarial relationships may arise due to a perceived difference in goals (Roth et al., 2016; Waller-Wise, 2018). Improving the relationships between doulas and nurses may improve outcomes for women.

### **Summary**

This paper aims to create guidelines to improve collaboration between nurses and doulas. Doulas are becoming more common at births in the United States; the number of births attended by doulas doubled from 2007 to 2013, and more than a quarter of women who knew what a doula was but did not have one expressed interest in having one (Declercq et al., 2007, 2013). Doulas improve outcomes for women. Their presence at births reduces the rate of C-sections, shortens labor, and reduces rates of intrapartum analgesia (Bohren et al., 2017). The purpose of this literature review is to examine existing theories on the role of the doula in a care team and to identify areas where interprofessional collaboration can be fostered. These findings and the personal experience of the author as a doula will be the foundation for recommendations to facilitate collegial relationships between doulas and the care team.

## CHAPTER 2

## Review of Literature

A literature search was conducted to find research and expert opinion on the collaboration between nurses and birth doulas. The research covered in this review was found through CINAHL and PubMed and was published during or after 2010. Search terms included “doula,” and “birthing companions. The author individually reviewed results to confirm subject matter and relevance to the research question.

**Doula services within a healthy start program: Increasing access for an underserved population**

This quasi-experimental study examined the outcomes of women enrolled in a doula program called the By My Side Birth Support Program (BMS). This program provides doula care to women in the New York neighborhoods of East New York, Bushwick, and Bedford-Stuyvesant (Thomas et al., 2017). The program included three prenatal home visits, support throughout labor and delivery, as well as two to four post-partum visits. The researchers compared the birth outcomes of the women enrolled in the program with the birth outcomes of women in the program area.

Women enrolled in the BMS program were more likely to be non-Latina black, be enrolled in some form of public insurance, were generally more educated, and were more likely to seek prenatal care in the first trimester (Thomas et al., 2017). Rates of Caesarean section were lower among BMS participants (33.5 vs 36.9%), but this difference was not statistically significant ( $p = 0.122$ ) (Thomas et al., 2017). However, the lower rates of preterm birth and low birthweight were significantly significant. 6.3% of BMS participants had a preterm birth compared to 12.4% of the wider population ( $p < .001$ ), and 6.5% of babies born to BMS

participants had a low birthweight when compared to 11.1% of the wider population ( $p = .001$ ) (Thomas et al., 2017).

The demographic differences between the women in the BMS program and the women acting as a control group is a weakness of this study. The differences in demography could be a source of confounding and may be responsible for some of the altered outcomes. However, the BMS program itself is a very good example of a comprehensive doula program. The scope of this program's intervention provides a basis for comparison with other studies that may involve less intensive programs.

### **Doula care, birth outcomes, and costs among Medicaid beneficiaries**

This quasi-experimental study looked at the differences in outcomes and costs between Medicaid-funded singleton births that were attended by a doula, and those that were not. The women in the doula group received care from Everyday Miracles, a group that employs 22 active DONA-certified doulas in Minneapolis, MN (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013). Doulas from Everyday Miracles provided education on childbirth and breastfeeding, continuous support throughout labor and delivery, and pre and post-natal care (Kozhimannil et al., 2013).

Women in the group that received doula care were slightly older, more ethnically diverse, and had lower reported rates of gestational hypertension than their counterparts, which is a potential source of bias. The women who had doula support had a significantly lower rate of Caesarean section than the women who did not receive doula care (22.3 vs 31.5%,  $p < .005$ ) (Kozhimannil et al., 2013). In other words, receiving doula care was associated with a 41% reduction in odds of C-section birth (Kozhimannil et al., 2013). Researchers also found that



doula care had the potential of reducing Medicaid costs associated with childbirth in three different payment models (Kozhimannil et al., 2013).

A weakness of this study is that it only follows one program in one city in the country. This means that its data may not be generalizable to the greater Medicaid population. One strength is that it analyzes the possible financial benefits of doulas in addition to the health benefits. A current barrier to doula care is the fact that women who may benefit the most from a birthing companion are least likely to be able to afford it. Showing that doula care has financial benefits may lead to more widespread coverage among insurance providers.

### **Potential benefits of increased access to doula support during childbirth**

This quasi-experimental study assessed the characteristics of women who received doula support and women who desired but did not receive doula care. This specific study aimed to see if improved outcomes were seen in just women who received doula care or in all women who were interested in it, a possible source of confounding in previous studies. This paper examined data from the nationally representative Listening to Mothers III survey of women who gave birth to a single child in the United states from July 1, 2011 to June 31, 2012 (Kozhimannil, Attanasio, Jou, Johnson, & Gjerdingen, 2014).

Women who received doula care had 60% reduced odds of Caesarean section ( $p < .005$ ), and 80% reduced odds of nonindicated (due to prior Caesarean, labor talking too long, concern for size of baby, mother's fear of vaginal delivery, or being past due date) Caesarean delivery ( $p < .005$ ) (Kozhimannil et al., 2014). This pattern was not seen in women who indicated desire for doula care but did not receive it. In fact, these women had higher odds of receiving a C-section and higher odds of receiving non-indicated C-section deliveries (Kozhimannil et al., 2014). This indicates that desire for doula care alone does not lead to better outcomes.

The Listening to Mothers III survey was weighted according to potential sources of bias and was nationally representative, and included extensive demographic data (Kozhimannil et al., 2014). However, one weakness of this study is that the data is retrospective. While it is a representative sample, the data relies on reports from women after the fact, which may not be entirely accurate.

### **North American Nurses' and Doulas' Views of Each Other**

This qualitative study aimed to discover what factors lead nurses and doulas to view one another positively. The authors hypothesized that nurses that are more experienced or work alongside doulas more often will have more positive views of doulas and that doulas who work primarily at one hospital or are certified will have more positive views of nurses (Roth et al., 2016). The authors also hypothesized that nurses who value labor support as much as or more than clinical tasks will have more positive views of doulas, while those who have more positive attitudes toward typical obstetric protocols will have more negative views of doulas. Finally, doulas who value typical obstetric protocols will have more positive views of nurses (Roth et al., 2016).

The data used in this study were drawn from the Maternity Support Survey, a survey of doulas, labor and delivery nurses, childbirth educators, and doulas in the US and Canada. The online survey was distributed through professional organizations including AWHONN and DONA international. Their sample included 1,470 doulas and 704 L&D nurses. The authors used existing questions to create a scale measuring doulas' attitudes towards nurses and nurses' attitudes toward doulas (Roth et al., 2016).

In general, the hypotheses of the authors were confirmed. Doulas tended to have a more positive view of nurses than nurses did of doulas. The authors concluded that the single most

significant barrier to collaboration between nurses and doulas is professional centrism, which they define as “a preferred view of the world held by a particular occupational group,” (Roth et al., 2016). Busy, stressed nurses may view the presence of a doula as a barrier to providing care. Ultimately, bias toward members of one’s own profession is a significant stumbling block to the effective collaboration of nurses and doulas (Roth et al., 2016).

### **Communicatively making sense of doulas within the U.S. master birth narrative:**

#### **Doulas as liminal characters**

The authors of this study establish birth in the United States as following what they term a “master narrative.” In this master narrative, there are archetypes and characters that expectant mothers, providers, nurses, and partners are expected to fill throughout the experience (Horstman, Anderson, & Kuehl, 2016). In this narrative, nurses and doctors are the main characters, and doulas do not yet have a solid place in this narrative yet.

In order to better define this place, the authors of this descriptive qualitative study interviewed birthing parents, doulas, and obstetric staff at one hospital in the United States, specifically nine moms (three of whom used a doula), 12 expectant mothers and nine expectant partners, eight doulas, five doctors, and nine nurses (Horstman et al., 2016). The authors conducted 30-60-minute interviews with the staff and mothers and held three-hour focus groups for expectant parents (Horstman et al., 2016).

The authors then used Tracy’s two-phase iterative analysis to code and categorize the themes of the interviews. Authors found doulas played many roles in providing care. The doula acted as a liaison, a bridge between family and medical staff; as a coach, connecting the mother with her support people; an advocate, involved in decision-making and finding mom’s voice; a fill-in, for the nurse, absent support person, or the partner (Horstman et al., 2016). Additionally,

doulas were seen as an extra (albeit unessential) set of hands and eyes, and occasionally as a stranger by those who did not like doulas originally (Horstman et al., 2016).

Horstman et al.'s study helps show that continuing to analyze and further define the role of the doula in general American culture as well as individual birth spaces is useful to normalize their practice and increase their effectiveness. Master narratives are a helpful way to conceive of the self-anthropology birth in individual cultures. Doulas play many roles in this narrative and are currently best defined as liminal characters (Horstman et al., 2016).

### **Midwives' and doulas' perspectives of the role of the doula in Australia: A qualitative study**

This qualitative study interviewed doulas and midwives in Australia with the goal of exploring and defining the role of doulas in Australian maternity care. The study interviewed convenience samples of six doulas and 14 midwives (Stevens, Dahlen, Peters, & Peters, 2010). Potential participants were contacted through email or telephone and used snowball sampling to recruit individuals. Midwives were required to have three or more years of experience, to be currently practicing, and to have experience working with doulas. Doulas had to have attended doula training and be currently practicing. Participants could not have practiced in the opposite position to be a part of this study (Stevens et al., 2010).

Interviews were conducted in focus groups of five to six individuals of the same professional group. The authors then performed a thematic analysis on the transcripts to identify themes. One prevalent theme was the broken maternity system (Stevens et al., 2010). The maternity care system is failing women and their caretakers; it is fragmented, overloaded, and dominated by a medical perspective that does not allow for significant discourse around the promotion of physiologic birth (Stevens et al., 2010). Among doulas, doulas were perceived as

‘filling the gap’ in maternity care (Stevens et al., 2010). Where continuity of care is not prioritized, the doula is readily available before the birth and present throughout the entire birth (Stevens et al., 2010).

Some midwives saw doulas as ‘taking our role’ (Stevens et al., 2010). Midwives navigating the broken maternity care system felt unable to provide women-centered care. What the doulas saw as ‘filling the gap,’ midwives perceived an unwelcome encroachment onto their territory (Stevens et al., 2010). They also expressed frustration at their previous experiences with doulas providing incorrect or misleading information to their clients (Stevens et al., 2010).

By far the most significant theme was the broken maternity care system, and the authors conclude that conflict between doulas and midwives is by and large a result of this dysfunction (Stevens et al., 2010). Women feel like they have little or no choice during birth and the authors feel that there is not enough support and education for birthing people. Based on the midwives reports of inaccurate information, the authors conclude that doulas may benefit from more regulation or a better-defined role (Stevens et al., 2010).

### **Summary**

Doula care is associated with an up to 60% reduced odds of C-section delivery, reduced rates of preterm birth, and reduced risk of low birthweight (Kozhimannil et al., 2014; Thomas et al., 2017). Furthermore, doula care is a financially viable method to improve maternal and infant outcomes among Medicaid patients (Kozhimannil et al., 2013). None of the studies in this review were randomized controlled trials, even though this topic is suitable for such a design.

The key finding of this literature review as it relates to the role of the doula is that doulas are a very useful part of the care team but may benefit from a better-defined role and scope of practice. Currently, the exact role of the doula is not well defined, and nurses who have not

worked with doulas before may develop adversarial relationships with them due to a perceived sense of conflict (Stevens et al., 2010; Roth et al., 2016).

More research is needed on how to integrate doula care into the modern healthcare system. The most effective doula care is provided by trained individuals that are not previously known to the patient and includes prenatal visits, both to establish a relationship between the mother and the caregiver and allow time for education on what to expect throughout the birthing process (Thomas et al., 2017).

Nurses should welcome the presence of doulas and birthing companions during labor and delivery because of the improved outcomes for mothers and infants. Potential methods to facilitate collaboration between doulas and nurses include increased interprofessional collaboration between the two professions and better education on the scope and role of the doula (Roth et al., 2016). Chapter four will go into more detail on best practice recommendations for nurses to support the integration of doulas into the care team.

## CHAPTER THREE

## Discussion of Author's Experience as a Doula

I was fortunate to undergo training as a doula under the expertise of DONA International doula instructor, Penny Bussell-Stansfield. In order to become a DONA-certified doula, individuals must attend a training workshop, a brief breastfeeding workshop, and a childbirth class. In addition to these events, candidates must read several books and attend at least three births, only one of which can be a Caesarean.

Training workshops included an eight-hour course on the physiology and anatomy of normal childbirth, sixteen hours of training on labor support over a weekend, and a three-hour long course on breastfeeding. Three births must be written up with examples of support provided and signed evaluations from the client and someone present at her birth. These are submitted to DONA International and reviewed before certification is conferred.

As a student doula, I was able to attend three very different births. The first was a Caesarean birth at 32 weeks because of intrauterine growth restriction (IUGR). This young woman had no other support persons present and had been followed by maternal fetal medicine and an obstetrician throughout her pregnancy. In the last weeks of her pregnancy, she was getting daily non stress tests and weekly biophysical profiles. Throughout this experience, I did not meet her obstetrician. The primary individuals with whom I interacted were nurses, both in labor and delivery waiting for the surgery and in the OR during the procedure. The doula techniques I used with this client mostly included acting as a support person at appointments and assisting her with relaxation techniques such as hand and foot massage as her birth approached.

Interactions with clinicians were brief, and rarely involved options for serious discussion of questions or concerns. By the time I had arrived, the decision for a cesarean section was made,

and the mother was just getting occasional updates on baby's strips. The client's Caesarean was urgent, but not emergent; her estimated time was delayed by a mom who needed an emergency Caesarean. Most of my interactions with the client and nurses were discussing the timing around her surgery.

In the operating room, I was surprised by the nonchalance of doctor and anesthesiologist. While the obstetrician preparing my client for her birth in the operating room, he carried out a casual personal conversation with the rest of the surgical team. I understand that these procedures are routine for members of the OR team, but this was a momentous and terrifying event for my client.

Her first child was being born. Her fiancée and the father of her child was across the ocean with the military and her baby was being born two months early. Prior to the surgery my client began to experience signs of panic; she was breathing fast and her voice was shaky. I did not feel comfortable inserting myself and holding space for my client in this situation because I felt that my role in the birth was not clear to everyone in the operating room. My ability to assist my client would have been better if that were the case. It is important that all members of the care team are aware of the presence of the doula and her role at the birth.

The second birth I attended was an induction at 41 weeks and 5 days. This mother was supported by her husband and mother-in-law. Her birth was attended by midwives from the local birth center. I was present with this client for about 20 hours, about half of which was without analgesia. I had very pleasant experiences with her care team. I was able to discuss her care with the midwives that were on call during her stay and with the nurses who took care of her.

For this birth, due to length and nature of the labor, I used a wide variety of doula techniques. These included hand and foot massage, breathing guidance, counterpressure, hip



squeezes, and focusing techniques. Social and emotional support was very important during this birth in addition to physical comfort measures. For example, the client was fine with her mother-in-law's presence during the labor but wanted only her husband and me for pushing and birth. I was able to ask her if this was still her desire and encourage her and her husband to assert it.

My one negative experience with this birth was with a nurse who was orienting on the unit. The birth occurred very close to shift change, so there was some overlap with the night nurse and the oncoming nurse and her orientee. My client had an epidural; during pushing I had been holding one leg and her husband held the other. When delivery appeared imminent, the orientee all but shoved me out of the way. This was startling to me. Had the nurse let me know ahead of time that she needed me out of the way, I would have happily moved at the tap of a shoulder.

My comfort with the nurses and midwives caring for my client allowed them to share concerns with me. When the midwife stepped in to provide more hands-on care, I felt comfortable in my scope of practice and that my role was respected. Additionally, the nurses and midwives I worked with seemed to have a good understanding of the role and scope of the doula.

The third birth I attended was precipitous and while it is useful experience for me as a birth worker, it had less impact on a conversation about building a care team, as I was present at the hospital for about two hours, including post-partum support. Doula techniques in this case primarily consisted of breastfeeding support after the birth and emotional support following the birth.

This birth was attended by a midwife, who was familiar with my scope of practice and the role of the doula in birth. The nurse introduced herself to me when she started work, as the

birth happened close to change of shift. She was comfortable with my ability to provide breastfeeding support and our practices were complimentary.

Ultimately, greater communication with care providers allowed me to perform my role as a doula more effectively. Part of this had to do with the amount of communication that occurred directly between the provider and the patient. The patient who received care from midwives was the only patient receiving care from the midwifery group at that hospital for much of her labor. This meant that the midwives were able to be present for a large portion of her labor, and communication was frequent and easy.

In contrast, I was present with the mother who gave birth via Caesarean for approximately 10 hours, but I only saw the obstetrician for about 5 minutes prior to the surgery and in the OR. The first two of the mothers that I assisted were first-time mothers, and a large part of my role with them was facilitating conversations between them and their providers. This included ensuring that they had all of their questions answered and that they had the time to ask any questions they did have. When the providers were minimally present, these conversations couldn't happen.

This led to interactions that made it more challenging for me to stay within my scope of practice as a doula, which I did. Doulas are not clinicians, and clients had questions that I did not feel comfortable answering as a birth aide. I imagine that this is where conflict can arise between clinicians and doulas. In the absence of effective and frequent education, doulas may feel pressured to provide information that goes beyond their solid knowledge, which may or may not be entirely correct. This leads to tension between clinicians and the doula, as the clinicians become frustrated by misinformation and miscommunication.

My experiences may be tied to the differences in models of care between midwives and obstetricians. The midwifery model tends to focus more on hands-on support during labor and social and psychological well-being in addition to physical needs. In my experience, this has translated into better and more frequent communication directly between providers and patients. At the births I attended, communication between an obstetrician and their patient occurred with the nurse as an intermediary.

For nurses, it is important to understand who is present during a woman's labor. I frequently experienced the assumption that I was a sister or sister-in-law of the patient, which was not corrected until several hours into the nurse's shift. This is in part on me as the doula, but several times during shift change, I was occupied with actively supporting my client or off having a snack. I believe that knowing the relationship between everyone present at a patient's labor is important to provide better care to the patient. This is important as the doula is likely aware of the client's hopes for the birth and may be a valuable source of information for the nurse.

Ultimately, I was better able to serve my clients when doctors, nurses, and midwives communicated openly with me. Doulas are a unique contributor to a care team in that they have no relationship with the hospital. That being said, communication between clinicians and doulas allows nurses to better care for patients and doulas to better care for clients. Chapter four will make recommendations to facilitate and improve collaboration between doulas and the rest of the care team.

## CHAPTER FOUR

### Recommendations and Conclusions

Doulas improve outcomes for women and their infants (Bohren et al., 2017). Continuous labor support from a trained doula is associated with a 25% reduction in Caesarean birth, and an 8% increase in the likelihood of a spontaneous vaginal birth (Bohren et al., 2017). Continuous labor support of any kind is associated with a 10% decrease in the use of any analgesia, a 38% reduction in risk for a low five minute Apgar score for the infant, and a 31% reduction in the risk of the laboring woman being dissatisfied with their birth experience (Bohren et al., 2017). When doulas are present, they are valuable members of the care team; nurses working with laboring women should be comfortable with working with doulas and skilled in integrating them into the care team. This chapter will give recommendations for doulas and nurses in the system as it exists now and outline suggestions for creating a better system.

### **Improving the System as it Exists**

There are several ways that nurses can support the integration of doulas into the maternity care team in an inpatient setting. The two primary methods to increase collaboration include improving education of the nursing staff and practices that nurses can adopt on the individual level.

### **Improving Education**

One way to improve collaboration between doulas and nurses is better education. Roth et al.'s study suggests that a potential barrier to improving the partnership between nurses and doulas is a lack of understanding of the doula's scope of practice and role in the intrapartum space on the behalf of nurses (2016). Therefore, educational programs to increase understanding

of the role of the doula may improve interprofessional collaboration. The level of support for this recommendation is level IV.

One potential method to improve this understanding is in-person trainings provided by the hospital in collaboration with unit nurse educators and community doula leaders.

Informational posters and training seminars may help increase nurse's comfort in working with doulas. Nurses who understand the scope of practice and role of a doula may feel more comfortable incorporating the doula into care activities.

To implement this recommendation, PDSA cycles (Plan-Do-Study-Act) will be performed. The PDSA cycle serves as a framework for the implementation and refinement of quality improvement projects in healthcare (Institute for Healthcare Improvement, 2019).

**Plan.** For this project, planning should involve collaboration with community doula leaders. These individuals can serve as liaisons between clinical professionals and doulas and assist in the development of curriculum. Planning will include scheduling and staff sign ups. This meeting should be an hour and a half, and employees should be compensated for their attendance to serve as an incentive. Considerations for scheduling should include the availability of both day and night shift nurses. In the early stages of this project, attendance should be capped to approximately eight nurses in order to best follow the PDSA framework (Institute for Healthcare Improvement, 2019). Furthermore, planning includes the outlining of a clear goal (Institute for Healthcare Improvement, 2019). In this case, the goal of the project is providing education on the scope of practice and role of the doula in order to facilitate their integration into the intrapartum care team.

Finally, planning includes developing strategies for the evaluation of the effectiveness of the intervention (Institute for Healthcare Improvement, 2019). In this case, evaluation should

include a brief pre- and post-survey taken online to evaluate both the nurse's perception of working with doulas and their knowledge of the scope of practice of the doula. Pre-testing should occur at sign up rather than immediately before the meeting in an attempt to mitigate participant bias from remembering their answers to the questions. Once exact questions are formulated, predictions for the improvement can be performed.

**Do.** In this project, “doing” entails the holding of a staff meeting. One hour will be reserved for a presentation on the role and scope of the doula. This presentation should include common techniques used by the doula, the training that doulas receive (in general terms, as there is no centralized education or licensing for doulas), and strategies for dealing with potential perceived conflicts between doulas and nurses. The presentation should also include education on the beneficial maternal and infant outcomes associated with the use of a doula. The remainder of the meeting can be used for an open question and answer period between doulas and nurses. When nurses sign up for the training, they will be prompted to complete a ten question “pre-test” survey online. At the end of the training, nurses will be asked to complete the same ten question survey as a “post-test.” They will have a maximum of three days to complete it.

### **Individual Practice**

At the individual practice level, nurses must be aware of the role of each support person in the room. It is possible that doulas may not be easily recognizable as a professional among support persons; any strategies to integrate doulas into a care team will not be useful if the nurse is not aware of the doula's presence. Nurses should view the doula as a valuable resource on the desires of the patient. Ultimately, the patient must be the final source of information, but the doula may have valuable insight into the patient's hopes for the birth or birth plan. At births attended by doulas, nurses should initiate a sort of ‘report’ from the doula. The nurse could ask

the doula what has been most helpful in managing the patient's pain and important highlights of the patient's birth plan. This should occur at the patient's bedside to allow the patient the opportunity to correct and add information as needed. This recommendation is based on the personal experience of the author while working as a doula.

For doulas working in the hospital, it is important to have a high degree of professionalism and introduce one's self to each member of the care team present at the birth. Doulas should wear nametags and have quick reference information sheets available to give to nurses or physicians who are not familiar with the role of the doula. These points are clearly outlined in the DONA International birth doula training, though not all doulas are trained and/or certified. This recommendation is based on the personal experience of the author as a doula and DONA International's code of ethics and scope of practice (2017). This is level VII evidence.

Furthermore, it is important for doulas to maintain a strict scope of practice in order to maintain positive relationships with members of the care team proficient in clinical tasks and obstetric protocols. DONA International has a strict scope of practice and code of ethics that its certified birth doulas are required to abide by (2017). This code of ethics and scope of practice should apply to all doulas; all doulas should be licensed or certified by a governing body in order to practice. This recommendation is based on a paper by Waller-Wise suggesting methods to improve relationships between nurses and doulas, level VII evidence.

### **Moving Towards a More Collaborative System**

A vitally important part of cultivating better partnerships between doulas and nurses is proximity. Research shows that doulas who work with nurses more often have better views of nurses and vice versa (Roth et al., 2016) (level IV evidence). When practicing as a doula, the author was able to provide better, more effective care with practitioners that were more familiar

with working with doulas. Building relationships between individual doulas and nurses is difficult in the system as it exists now. While some hospitals have piloted programs where doulas volunteer to work at the hospital (Lanning & Klamman, 2019), the decentralized nature of the doula community means that it may be uncommon for doulas and nurses to work together more than once.

Due to the nature of the profession, one doula will not likely attend enough births at a particular hospital to form familiar relationships with staff nurses, unless hired by the hospital or working for extended periods of time. One survey of the intrapartum care team's views of one another demonstrated that doulas and nurses have more positive views of the other members of the care team when they work with them more (Roth et al., 2016). Furthermore, Waller-Wise posits that increased interdisciplinary collaboration between doulas and nurses is important to prevent the development of adversarial relationships and foster trust between the two groups (2018).

This author believes that the best way to form better care teams for intrapartum women is for hospitals to invest in the hiring and training of doulas. Hospital-based doula programs would allow administrations to enforce a scope of practice and hold interdisciplinary trainings that focus on collaboration between labor nurses and doulas. This model would also provide recourse and structure to resolve conflicts between members of the care team and to allow for discipline if necessary. This recommendation is based on the professional opinion paper of Waller-Wise, level VII evidence, and Roth et al.'s case control study, level IV evidence (2018, 2016).

Implementation of this system could once again use PDSA cycles a framework.

## **Plan**



The planning stage for this project will begin with brainstorming and research into similar programs that have been implemented in other American hospitals (Institute for Healthcare Improvement, 2019). Planning for this project would include the creation of a budget for the training and hiring of doulas. The facility could collaborate with DONA International doula trainers in the community to provide training for new hires and investigate the possibility of hiring or contracting with experienced DONA International-certified doulas. This budget must include the advertisement and roll out of the new program, including the education of providers who would refer patients to the program.

Another important planning activity is the establishment of a clear objective (Institute for Healthcare Improvement, 2017). In this case, the objective of this project would be the development of a hospital-based doula program that works alongside labor and delivery nurses, midwives, and physicians to provide more effective care to women giving birth.

Finally, planning includes developing strategies for the effectiveness of the program (Institute for Healthcare Research, 2017). In this case, statistics of interest include caesarean rate for both medically indicated caesareans and non-indicated caesareans (such as failure to progress, prior caesarean, and maternal fear of vaginal delivery), use of any pain medication, use of epidural analgesia, preterm birth rate, low birth weight, and maternal perceptions of birth experience.

## **Do**

The do stage of the PDSA cycle involves implementing the plan on a small scale in the initial trial periods (Institute for Healthcare Improvement, 2019). A few doulas will be hired or trained and providers who attend births at the hospital can refer patients that express interest in using a doula.

Research suggests that doula care is most effective when provided by an individual who has a relationship with the laboring woman prior to the birth (Thomas et al., 2017) (Level IV evidence). Furthermore, a vital role of the doula is to gather information on the needs and desires of the family she is supporting and to provide emotional support prior to the labor (DONA International, 2012) (level VII evidence). Doulas should have at least one prenatal meeting with the client before the birth in order to establish a relationship with the client. The doula should also have one meeting with the client after the birth to assist her in processing the experience, an important role for birth doulas (DONA International, 2012) (level VII evidence).

A system like this has the potential to increase the effectiveness of interdisciplinary care teams by fostering collaboration. Nurses and doulas could form familiar relationships, which fosters more positive attitudes toward other professions (Roth et al., 2016) (level IV evidence). Furthermore, this system would give the hospital more control over the training and evaluation of doulas who work with the facility. A project of this size would take significantly more time and resources than a project that works within the system as it exists now but has the potential to increase the effectiveness of maternity care teams to a greater degree.

### **Summary**

Doulas improve clinical outcomes for women and their infants and parental satisfaction with the birth experience; their presence at births is becoming increasingly common (Bohren et al., 2017; Declercq et al., 2013). Nurses play a vital role in supporting the integration of doulas into the care team. Education of nurses, open communication between members of the care team and a common understanding of the scope of practice of the doula have the potential to increase harmony in the care team. Furthermore, a hospital-led program to contract with or hire doulas to

work at a particular facility has the potential to foster effective interdisciplinary collaboration between doulas and nurses on the intrapartum care team.

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